Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Home Health Care Provider Class Plan

# Table of Contents

# Provider Class

A provider class includes health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the scope of services for which reimbursement is made may differ for the types of providers within a provider class.

## Definition

A home health care provider under this provider class plan is a public agency or private organization that provides physician-prescribed skilled nursing care and various therapeutic services to members who are confined to their homes. The services must be provided through a centralized administration that uses coordinated planning, evaluation and follow-up procedures.

## Scope of Services

Home health care providers primarily render skilled nursing care. They also provide one or more of the following types of services in order to maximize the health, independence, dignity and comfort of the patient:

- Physical and occupational therapies
- Speech-language pathology
- Medical social work
- Nutrition counseling
- Home health aide services

# PA 350 Goals and Objectives

Provider class plans are developed and maintained pursuant to section 504 of PA 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

## Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left( \frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

### Objectives

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement.

## Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

## Objectives

- Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration.
- Maintain and periodically update a printed or Web site directory of participating providers.

# Quality of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

## Objectives

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards.
- Meet with specialty liaison to discuss issues of interest and concern.
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes or disputes regarding utilization review audits.

# BCBSM Policies and Programs

BCBSM maintains a comprehensive set of policies and programs that affect its relationship with health care providers. These policies and programs are designed to help BCBSM meet the PA 350 goals and objectives by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the PA 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

## Provider Participation

Providers may formally participate with BCBSM or, with respect to some provider classes, providers may participate on a per-claim basis. To formally participate, providers must sign a participation agreement with BCBSM that applies to all covered services the provider renders to BCBSM members. To participate on a per-claim basis, providers must indicate on the claim form that they are participating for the services reported.

### Participation Policy

Participation for home health care is on a formal basis only which means there is no "per-claim" participation. Home health care services rendered by a nonparticipating home health care provider are not reimbursed. In order to participate, providers must meet all of BCBSM's qualification standards.

### Qualification Standards

All home health care providers may apply to participate with BCBSM. Standards for formal participation include, but are not limited to the items listed below. Home health care providers' credentials are periodically reviewed to ensure participation requirements are maintained.

Participating home health care providers must meet the following qualifications:

- Current Medicare certification as a home health care provider or accreditation for home health care by:
  - The Community Health Accreditation Program, Inc. (CHAP) or
  - The Joint Commission on Accreditation of HealthCare Organization (JCAHO)
- Current membership in any one of the following professional organizations:
  - American Public Health Association (APHA)
  - National League for Nursing (NLN)
  - Michigan League for Nursing (MLN)

- American Federation of Home Care Providers, Inc. (AFHCP)
- American Association for Homecare (AAH)
- National Association of Home Care (NAHC)
- Visiting Nurses Association of America (VNAA)
- Michigan Home Health Association (MHHA)

- Written policies and procedures that meet generally acceptable standards for home health care services to assure the quality of patient care, and demonstrate compliance with such policies and procedures
- Demonstrated program evaluation and utilization review programs to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components
- Multi-disciplinary staff composed of all of the following:
  - A nursing administrator or coordinator who is a Michigan licensed registered nurse and who directs the activities of nurses, therapists and other staff members
  - A business office manager who handles the business and financial aspects of the program
  - A physician coordinator, licensed in Michigan, who serves as consultant, advisor, and liaison between the facility and the medical community
  - Michigan licensed registered nurses
  - Michigan licensed physical therapists, occupational therapists or social workers, as appropriate to the services provided by the facility
- Provisions for skilled nursing services and one of the following professional types of service: physical therapy, speech therapy, nutritional therapy, occupational therapy or medical social services
- BCBSM's Evidence of Necessity requirements, as applicable
- Governing board must be legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the home health care provider as a community facility.
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and absence of fraud or illegal activities
- Maintenance of adequate patient and financial records

## Termination of Contract

The participation agreement may be terminated immediately by BCBSM if the provider fails to meet any qualification standard. It can be terminated by either party, with or without cause,

upon 60 days written notice to the other party. Other stipulations for terminating the participation agreement are outlined in the Home Health Care Facility Participation Agreement.

# Provider Programs

BCBSM strives to ensure that members receive appropriate and quality care through a combination of provider communications, education, and quality assurance programs.

## Utilization Management Initiatives

BCBSM works to ensure that only medically necessary services are delivered to members through utilization management and quality assessment programs.

## Communications and Education

BCBSM provides the following resources to communicate with and educate home health care providers:

- *The Record*, a monthly BCBSM publication that communicates current information regarding billing guidelines, policy changes and other administrative issues.
- An online manual that provides information on how to do business with BCBSM explains billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements, the Home Health Care Provider Participating Agreement, and its administration. BCBSM maintains and updates this manual as necessary.
- A provider directory on the BCBSM Web site which includes a current list of participating home health care providers.
- Continuing medical education seminars
- The liaison process that provides a forum in which specialty societies can bring issues of concern to BCBSM's attention. The process can include meetings with specialty societies as well as contact with BCBSM representatives by telephone or email.

## Performance Monitoring

- Home health care providers are surveyed regularly to ensure that professional credentials and qualification standards are maintained and up-to-date.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Utilization review audits, when conducted, work to ensure that providers rendered services appropriately and within the scope of members' benefits.
- BCBSM uses InterQual ISD-HC® (Intensity, Severity and Discharge Screens, Home Care) criteria to determine medical necessity. These criteria are supplemented by a limited number

of BCBSM medical policy rules. BCBSM medical policy rules must be met before InterQual ISD-HC criteria can be applied. BCBSM's prospective and retrospective utilization management areas use these criteria.

### Appeals Process

BCBSM's appeals process allows providers the right to appeal adverse claim decisions and utilization review audit determinations. The process is described in Addendum E of the Home Health Care Facility Participating Agreement.

## Reimbursement Policies

BCBSM reimburses participating home health care providers for covered services deemed medically necessary by BCBSM. Addendum A of the attached Home Health Care Facility Participation Agreement describes determination of medical necessity.

### Covered Services

BCBSM reimburses for the following services when provided by a participating home health care provider in accordance with member certificates:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech and language pathology
- Nutritional assessment and counseling
- Social service guidance
- Home health aide services

### Reimbursement Methods

Reimbursement is made only for covered services provided by a participating home health care provider.

### *Freestanding Home Health Care Providers*

For each covered service, BCBSM pays the provider the lesser of allowable costs or billed charges, less member deductibles or copayments.

An interim percentage of charge payment rate is initially determined for each home health care provider based on information submitted to BCBSM when the provider applies for participation. Thereafter, the provider's interim percentage of charge payment rate may be adjusted, as

necessary, to reflect retrospective settlement following BCBSM's audit or review of the provider's annual Home Health Cost Report.

Final payment settlement is limited to the lesser of allowable costs, as determined by BCBSM, or billed charges for covered services.

BCBSM will periodically review freestanding home health care provider reimbursement to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

### *Hospital-based Home Health Care Providers*

Reimbursement is determined by the parent hospital's peer group assignment as defined in Exhibit B of the Participating Hospital Agreement (PHA), and as supplemented by the PHA Payment Manual. A home health care provider that is owned and operated by a hospital and considered a peer group 1-4, 6 or 7 hospital, will be reimbursed using a prospectively established hospital-specific cost-to-charge ratio for home health care services, less member copayments and deductibles. This cost-to-charge ratio will be established and updated in accordance with the policies explained in Exhibit B of the PHA.

A home health care provider that is owned and operated by a hospital, and is considered a peer group 5 hospital, will be reimbursed at the same level established for that hospital's acute care services in accordance with Exhibit B of the PHA, less applicable copayments and deductibles.

BCBSM will review its reimbursement methodology for hospital-based home health care providers periodically to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

## Hold Harmless Provisions

Participating home health care providers agree to accept BCBSM's payment as payment in full for covered services. Member copayments or deductibles are subtracted from BCBSM's payment before the provider is reimbursed and are the member's responsibility. As outlined in Addendum G of the Home Health Care Facilities Participating Agreement, a participating home health care provider must hold members harmless from the following:

- Balance billing for covered services
- Liability for services that are not covered because they are not medically necessary or are experimental, unless the member agrees in writing to pay for the services before they are provided.
- Liability for covered services provided but not billed to BCBSM within a prescribed time frame.

# Home Health Care Facility Participation Agreement

The Home Health Care Facility Participation Agreement is attached.